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The New Look in Dental Health*

By W. PHILIP PHAIR, D.D.S., Secretary, Council on Dental Health, American Dental Association

One of the most frequently asked questions in America today is, "What's new?" Although the typical American has some set ideas—inherited prejudices and folklorish superstitions—he reads magazines and newspapers, listens to the radio, watches television and talks things over with his friends. And, in spite of his prejudices, he is always looking for something new, always hopeful a new brand of cigarettes will help his cough, that a new breakfast food will start his day off better tomorrow, that a new preparation will check his falling hair, that the newest tooth paste will help him hold his diminishing supply of natural teeth.

In the fashion world, the "new look" is a constant source of delight to style-conscious women and a continuing perplexity and expense to their husbands.

There is a striking dissimilarity, however, between the new look of the hucksters and designers of fashion and the new look that is ascribed to dental health.

A new look in dental health is not heralded every few weeks. The advancements in dental health usually gain acceptance rather slowly. The mark of distinction of today's new look in dental health is the scientific basis on which it has been developed.

PROGRESS IN HEALTH IMPROVEMENT

In the last decade, we have reduced the incidence of typhoid fever over 70 percent, measles by 80 percent, scarlet fever by 75 percent, whooping cough over 70 percent, diphtheria by 85 percent, influenza by 77 percent, tuberculosis by 50 percent, infantile

diarrhea by 77 percent and have almost eliminated other diseases, such as smallpox and rickets.

Speed in prevention of dental decay has not been as spectacular until a few years ago. We had been laboring away at the overwhelming problem of dental decay with a sort of "covered wagon" method. The approach had been slow and not too productive in providing adequate care for the many who needed it. The filling of dental cavities and the extraction of neglected teeth had been the standard procedure, while too little had been done to stem the tide through *prevention*—the key to 1954's new look in dental health.

Probably one of the largest deterrents to the attainment of optimum oral health today is the complacency that too often is accorded dental diseases. The public must learn to accept the fact that dental disease is not inevitable, that teeth do not necessarily have to become decayed and lost through neglect, that gum diseases are preventable and, in the early stages, subject to effective treatment. Modern measures can reduce the dental disease problem to a point where every individual, regardless of income or geographic location, can enjoy the benefits of good dental health.

FLUORIDATION

The impressive reductions in typhoid fever, smallpox and infantile diarrhea are due almost entirely to improvements in public health measures—chlorination, vaccination and pasteurization—and the Nation's public health authorities now rank fluoridation as one of the historical milestones in public health achievements.

*Presented at the Sixth Annual Children's Dental Health Conference, St. Francis Hotel, San Francisco, February 1, 1954, and condensed for *California's Health* by permission of the California State Dental Association.

In the short span of four years, the number of communities benefiting from this decay-preventive has multiplied 25 times—from 34 communities in January, 1950, to 865 communities with a total population of nearly 16,000,000 persons in January, 1954. Those who become discouraged by delay in adoption of the procedure in their individual communities should be heartened by the fact that, nation-wide, the public rapidly is recognizing the value of fluoridation in saving teeth and is investing in dental health.

The fluoridation of an increasing number of community water supplies is destined to influence profoundly the dental health of oncoming generations.

Despite the barrage of propaganda, deliberately designed to cause confusion and doubt, San Francisco citizens showed discerning judgment in voting overwhelmingly for dental health in 1951. The children of this city, who will be the adult citizens of tomorrow, are the ones who will be receiving life-long protection from dental decay.

Other California communities are adopting fluoridation, and those of you here today whose communities are not yet benefiting from the measure have a 1954 challenge in the active promotion of fluoridation. Your leadership is supported by an overwhelming accumulation of scientific data demonstrating that fluoridation will significantly improve general health through the reduction of dental decay.

Searches for possible harmful effects from ingestion of fluorides have been conducted for several years. Yet no scientist ever has been able to find any adverse physiological effects from fluorides in the amount recommended for protection against decay. Investigations into the charges of those who have opposed the measure show their fears to be based on sheer speculation, fragmentary and fragile evidence and misinterpretation of facts—never upon adequately controlled scientific studies by competent researchers. Many of the charges are not at all pertinent to the subject and show an immense lack of understanding of even simple scientific facts.

The efforts of the proponents of fluoridation must be directed to persons who have the perception to distinguish the sources from which various statements come.

It is important, too, that civic leaders and community organizations recognize the dental profession is anxious to assist in the fluoridation program in every way it can, but that the dental society serves the community best in providing technical and professional leadership.

Dentists are glad to bring to the attention of civic groups the importance of fluoridation and to interpret the scientific background supporting it. But the real "leg work" in getting fluoridation adopted and in

seeing that the program is maintained is the responsibility of appropriate community and civic groups and official health agencies.

Moreover, fluoridation represents one of the most remarkable features of the new look in dental health, because it exemplifies the modern method of dealing with public health problems. It is preventive in character, it is determined and applied at the community level, it is the result of organized effort on the part of the community's citizens and it is supported, not directly, by the health professions.

I have spent considerable time on the subject of fluoridation because, as dentistry's most effective and most practical preventive weapon against dental disease, it ranks as the first step any community should undertake in helping to improve the dental health of its future adult citizens.

TOPICAL FLUORIDES

In communities whose public water supplies are deficient in fluoride and in those areas not served by public water supplies, the children should receive direct applications of fluoride at periodic intervals. The applications are made by dentists. They are time-consuming and are not a substitute for fluoridation.

Topical fluorides will reduce the prevalence of dental decay among children by about 40 percent. Community organization is essential in bringing to the attention of parents in rural areas the need for this preventive technic so that children can receive its benefits either through the offices of their private dentists or in school and community dental health programs.

RESTRICTION OF SWEETS

Another highly important measure for the prevention of dental decay is the restriction of sweets. The relationship between sweets and dental decay has been well established, and if parents and school administrators are seriously concerned about dental decay they must stop pampering the "sweet tooth" of children.

Hundreds of investigations have shown the relationship between sweets and dental decay. Although many of the specific details about this relationship need yet to be learned, the fact that high and frequent sugar consumption is directly associated with dental decay is not disputed among the Nation's dental scientists.

It has been shown, for example, that the acid production on the surface of a tooth develops rapidly after the mouth is rinsed with a 10 percent sugar solution and reaches its maximum strength in enamel-dissolving ability within 18 minutes, to return to normal two hours later. The same concentration of sugar

ordinarily is found in soft drinks, and an even greater concentration in most candies, jams and sweet desserts.

It is not difficult to visualize the disastrous effects of almost constant acid production on the surfaces of teeth as the result of periodic consumption of sweet snacks, drinks and desserts. Important studies on this problem have been conducted at the dental colleges here in California. Dr. Hermann Becks at the University of California College of Dentistry was successful in halting dental decay in over 80 percent of a group of 1,228 patients for whom he recommended low-sugar diets. There are many other examples in which investigators and practicing dentists have been successful in controlling dental decay in persons sincerely interested in cooperating in a low-sugar diet program.

There are many who believe it is unrealistic and impractical to continue to urge restriction in sweets to a public that has become accustomed to a per capita consumption of about 100 pounds of sugar per year. That belief is nonsense. The fact is, there are many people who are sufficiently concerned about dental bills, dental ill health and the discomfort resulting from dental neglect that they will seriously attempt to follow good dental health practices.

The dental profession has a responsibility to inform the public about the dental health hazards of frequent consumption of sugar, and parents and school administrators have a responsibility not to make sweets a convenient substitute for more nutritious foods at meal time.

DENTAL HEALTH EDUCATION

Another highly important facet of the new look in dental health is the increasing emphasis given to dental health education. Several conditions account for this shift in interest. In the past, public health has been based on measures designed to control disease through mass procedures that require little individual responsibility; such as chlorination, pasteurization, food inspection, insect and rodent control and similar procedures. Today, many of our health problems are controlled only through action of the individual. For example, chronic diseases are our greatest cripples and killers, but with minor exceptions the best we can do about them in the light of our present knowledge is to find the disease early and to initiate treatment as a means of preventing further damage. Except for fluoridation, and even that requires a tremendous amount of community-wide education, advancements in individual dental health are largely dependent upon dental health education.

The dental profession in California is leading the Nation with its programs of dental health education.

I know of no other state in which dentists are spending so much time, money and effort in providing the public with authentic dental health information coupled with professional leadership to help community groups solve their dental health problems.

As a concrete example of effective dental health education programs, departments of health in Iowa and Minnesota publish annually a listing of the schools in the respective states where 100 percent of the students have obtained all needed dental corrections, each year showing an increase in the number of children with healthy mouths. A school in suburban Chicago last year graduated its twenty-fifth consecutive class with all students having met all dental needs.

These are examples where the 100 percent ideals have been achieved. But hundreds of schools throughout the Nation are making significant records in improvement in dental health, largely as the result of effective dental health education programs.

DENTAL CARE

Early detection and treatment of dental defects is still one of the most important dental health measures. Unlike most illnesses, such as the common cold, flu, measles and whooping cough, dental diseases are not self-limiting. While people usually get over a cold whether they treat it or not, dental decay is a progressive disease, continuing, with rare exceptions, to the point where, untreated, it results in infection and loss of teeth.

Studies have shown it takes three to five times as much professional time and effort to care for the accumulation of neglected dental needs of school children than it does to cope with those needs on a year-to-year basis. Saving teeth through regular care was demonstrated in one study that showed children who failed to get regular care loss *eight* times as many teeth as children whose teeth were cared for on a regular basis.

Gum diseases are rarely corrected without specific attention requiring treatment by a dentist and home treatment by the individual. Dental health education has an important role to play in helping people understand the need for early and regular professional attention and proper home dental hygiene measures. Dental health education also helps the dental profession to provide the highest standards of services to individuals who appreciate the value of dental health.

TEN "MUSTS" FOR BETTER DENTAL HEALTH

It seems appropriate to consider how the facts about dental disease and its prevention fit in with the purpose of your meeting. What conclusions can we draw from these facts that will help each of us do a better job in improving our own dental health,

that of our children and of the people in the communities in which we live? I should like to mention 10 "musts" which I believe all of us—school people, parents, representatives of various civic organizations, public health workers and dentists—should recognize, accept and put into practice:

1. *Dental Health Attainable.* The public must learn to accept the fact that dental disease is not inevitable. Good dental health is not for the few. It can be obtained for all through application of effective preventive measures, both at home and in the community—restriction of sweets, a healthful diet and early and regular dental treatment.

2. *Community Programs Effective.* The public and the dental profession alike must demonstrate their belief in the fact that, in America, needs can best be determined through individual and community effort. There are well-defined measures which community groups can undertake to improve dental health, chief among which is the fluoridation of public water supplies.

3. *Programs Based on Community Needs.* Community leaders must design programs that will best fit the particular needs and resources of their communities. Because one type of program is working effectively in one community, it may not necessarily work elsewhere.

4. *Dental Health Education a Continuing Endeavor.* All persons participating in this conference must recognize that one-day celebrations, widespread publicity, the distribution of pamphlets and the showing of films do not in themselves constitute a dental health education program. Publicity must never be an end in itself. This recognition does not mean that the public press and radio are an unimportant part of the dental health education effort. News stories, radio and television programs, pamphlets, talks and conferences are all "tools" of dental health education. But they are not ends in themselves.

5. *Dentists Active in General Health Field.* The dental profession must understand that schools and community health organizations have a great many more problems than that of dental disease, even though school administrators and civic leaders recognize the importance of dental health.

Every community has many important activities going on constantly, and dentists often will find it profitable to work with schools, health councils, health departments and similar organizations on other health problems, putting aside their concern for dental health temporarily while priority is given to problems considered by the public to be more critical at the moment.

6. *Scientific Fact as Basic for Programs.* The dentists must provide, and the public must accept, scientific fact as the basis for forming desirable dental health habits and for conducting community dental health programs. The dissemination of only those facts that can be substantiated by reliable evidence is a serious responsibility of a scientific profession, and the public must learn to judge critically the source of its scientific information.

7. *Acquirement of Facts Not Education.* Most of us must become less dependent on the dissemination of facts and give greater attention to methods of fostering an understanding about dental health. Understanding is essential if education is to be effective. Although reliance on fact-giving may be an easy method of dental health education, facts obviously are not enough. Helping students and the public in general to understand how they can achieve healthy mouths will tax the ingenuity, the resourcefulness and the energy of all who believe in the value of dental health education.

8. *Education Not Confined to Classrooms.* School administrators must demonstrate their belief that dental health education is not entirely confined to the classroom. It seems unrealistic that schools should encourage early and regular dental attention and then refuse to permit children to keep dental appointments during school hours. An "excuse" system, mutually agreeable to the schools and the dental society, can be arranged.

9. *Dentists as Resource People.* Dentists and dental hygienists must recognize the fact that dental health education in the schools is primarily the responsibility of the classroom teacher. Dentists and dental hygienists can serve as valuable resource people to the teacher, and the schools have a responsibility to show these consultants how best they can serve in that capacity. Dentists usually have had little or no training in teaching methods, but they do have scientific knowledge that schools must learn to use wisely.

10. *A Cooperative Approach to Dental Health.* We must put into action to the fullest our belief that dental health education is the responsibility of all—in the dental office, in the school, and in the home. Each of these areas is enhanced through community-wide activity that will help promote dental health.

Public Health Positions

Butte County

Sanitarian: Salary for this position is \$315 to \$391. A county car will be furnished. Applicants must possess certificate of registration as a sanitarian in California. Further information may be obtained from Richard C. Murphy, M.D., Butte County Health Department, P. O. Box 1100, Chico.

Home-canned Peaches Blamed for Botulism Deaths

California's first recorded cases of botulism from home-canned peaches resulted in three deaths in San Diego recently. The first two fatalities were those of a man and wife whose illness had been diagnosed as due to other conditions. The tragedy was compounded when two sisters of the dead woman came to attend the funeral and presumably ate from the same jar of toxic peaches which they had found opened in the refrigerator. Both became ill, and one died. A son of the dead couple, his wife and one of their two children also ate at the later meal when the peaches were served, but did not develop symptoms. The two sisters were treated with botulinus antitoxin after their symptoms appeared. The son and his family were treated prophylactically with the antitoxin.

Laboratory tests of sampled foods taken from the household yielded *Clostridium botulinus* toxin, Type A, from the opened jar of peaches. According to records of botulism cases compiled for the United States and Canada by Dr. Karl F. Meyer and Dr. Bernice Eddie of the George Williams Hooper Foundation, University of California, there are only two other instances reported in which canned peaches have been found to be the cause of botulism cases. Both of these instances were in New Mexico; one in 1944 when there were two fatal cases "due to home-canned peaches and pickles," and the other in 1947 when four fatal cases were traced to "home-canned peaches."

Acid fruits and vegetables are seldom the source of botulinus toxin. However, if contaminating organisms which attack sugar are present the pH value may change sufficiently to produce conditions favorable for the production of botulinus toxin. When the peaches that caused these California deaths were tested the pH was found to be 5.0. At pH 4.9 and above there is practically no inhibition of toxin formation.

In the investigation of the San Diego cases, relatives and neighbors stated that the woman who died had not followed recommended procedures for canning fruits and vegetables under steam pressure.

Events as reconstructed in the investigation by the San Diego County Health Department were as follows:

The husband was the first to become ill, on the evening of January 8th. His symptoms included vomiting and paralysis of the tongue. He was admitted to the hospital at 5.30 a.m., January 9th, and died at 10.15 a.m. On the evening of January 9th, his wife

developed respiratory difficulties and loss of voice. During the night she developed pronounced respiratory distress and exhibited symptoms of ocular and pharyngeal paralysis. She was dead on arrival at the hospital about noon on January 10th.

The two sisters of the dead woman arrived at the household on January 12th to attend the funeral. The son of the dead couple and his family also came for the funeral. On the afternoon of January 13th, following the funeral services, all of these people ate at the home and included in the food served was the jar of peaches which was already open when the sisters arrived.

Within 18 hours both sisters became ill with symptoms including vomiting, double vision, difficulty in swallowing, difficulty in talking and some respiratory difficulties. They were admitted to a local hospital and the clinical diagnosis of botulism was made. Botulinus antitoxin was administered immediately. One sister recovered, but the other died on January 29th.

In California during the period from 1940-1953 there were 69 outbreaks involving 140 cases of botulism, with 76 deaths. Seven of these outbreaks were traced to home-canned fruit, involving 13 cases and six deaths. The fruits included apricots, pears, figs, cactus and huckleberries. Forty-one outbreaks were traced to home-canned vegetables—beets, beet greens, asparagus, chili peppers and string beans.

In 1953 there were only two cases of botulism reported in the State. Neither died. One case resulted from eating home-canned string beans and the other from home-canned huckleberry juice.

Public Health Nurses Can Assist in Compiling Medicine Lore

Public health nurses can be of valuable assistance in the gathering of folk medicine lore for a Dictionary of American Superstition now in preparation at the University of California.

Wayland D. Hand, Professor of German and Folklore, recently was the recipient of a Guggenheim Foundation Fellowship to compile a standard collection of popular beliefs and superstitions. The dictionary would preserve many of the old folk medical beliefs and practices which are fast passing into oblivion.

Professor Hand said that nurses, particularly public health nurses, are in an advantageous position to collect such data. He seeks the assistance of physicians and others connected with the profession, as well.

A prospectus describing the project can be obtained by writing Professor Hand at UCLA, Los Angeles 24.

Suspected Smallpox Cases Investigated

During February two suspected cases of smallpox, one each in Fresno and Tulare Counties, were reported to the State Department of Public Health by the local health departments. Both cases proved not to be smallpox, but the incident demonstrated again the vigilance which the department's Bureau of Acute Communicable Diseases, in close conjunction with the local health departments, maintains for suspicious cases of smallpox throughout the State. This is part of a nation-wide surveillance activity, coordinated at the national level by the Communicable Disease Center, Public Health Service, Atlanta, Georgia.

The first case was a 27-year-old housewife admitted to the Fresno County Hospital severely ill with a pustular rash resembling, but not typical of, smallpox. Diagnostic consultation was requested of the Bureau of Acute Communicable Diseases by the Fresno County Health Department. Pending diagnosis, the patient was placed in strict isolation and all contacts were vaccinated. Investigation failed to uncover any possible source of smallpox infection in this patient. It was discovered, however, that her infant daughter had been vaccinated against smallpox just prior to onset of the mother's illness. As the mother had a known history of chronic dermatitis, it appeared reasonably certain that she had contracted a generalized vaccinia from contact with her daughter's vaccination lesion. The State Viral and Rickettsial Laboratory and the University of California Hospital have confirmed that her infection was due to a virus of the vaccinia-smallpox group.

The second case occurred in a Mexican laborer admitted to the Tulare County Hospital with a suspicious rash. With further observation, a diagnosis of scabies with secondary infection was established in this patient. Laboratory study of vesicular fluid showed no evidence of vaccinia or smallpox.

Although the last occurrence of smallpox among civilians in California was a single case in 1947, our geographic position provides a continual risk of introduction of infection from the Orient or from Mexico. To provide adequate protection against this disease, efforts are directed not only at maintaining a high level of immunity through vaccination, but also at early recognition and effective isolation of each new case which occurs in the State, thereby limiting its spread at the outset. This objective requires that every reasonably suspicious case be investigated immediately and precautions maintained until the diagnosis is established.

Vaccinia Immune Gamma Globulin Available for Clinical Use

Physicians who in their practice may have occasion to see complications of smallpox vaccination now have the offer of a new and promising therapeutic tool from the University of California Medical Center. Vaccinia immune gamma globulin, a solution of the globulin component of human blood collected from volunteer donors of the Armed Services who have been successfully vaccinated against smallpox from four to eight weeks prior to the blood donations, may also be used in the prevention of smallpox in the exposed susceptible contacts.

Dr. C. Henry Kempe, Department of Pediatrics, UC Medical Center, reports that this material has been tested in India for the specific prevention of smallpox in exposed susceptible family contacts of smallpox cases and that the experience indicates it is effective in preventing the disease under such circumstances. He reports that the Medical Center's clinical experience in the prevention and treatment of serious complications of smallpox vaccination has been more limited, but is promising.

Complications of smallpox vaccination include (1) generalized vaccinia, (2) eczema vaccinatum, and (3) progressive vaccinia (failure to produce specific antibodies) or vaccinia necrosum. While these complications are rare, the availability of this new method of treatment now offers assistance in the handling of these occurrences.

Dr. Kempe points out that the serum is unlicensed and is unevaluated as to its complete effectiveness. The material is available for clinical trial only. Dr. Kempe invites physicians to contact the Medical Center by telephone or telegram at the earliest possible moment when such cases are encountered in clinical practice, in contagion hospitals, in teaching centers, or in health department well-baby clinics. The Medical Center will ship immediately, free of charge, by air express, the required amount of vaccinia immune globulin for early use. The Medical Center does not have enough of the material at present to send supplies to local health departments for storage until needed.

Telegraphic or telephone requests should be addressed to:

C. Henry Kempe, M.D.
Department of Pediatrics
University of California Hospital
San Francisco 22, California
MO ntrose 4-3600, Extension 371

Calls will be received at night.

State Health Department Must Approve All Clinical Lab Training

The California State Department of Public Health must approve any training in the techniques of a clinical laboratory, according to a recent opinion of the Attorney General.

This opinion (53-245—February 15, 1954) was requested by the department after it was learned that certain private schools were conducting such classes without approval on the assumption they were not covered by the Business and Professions Code because their training did not prepare graduates for licensure as technicians.

The Attorney General, in his opinion, wrote, " * * * the operation of a school providing training in the techniques of a clinical laboratory, without having the approval of the Department of Public Health, is a violation of Section 1289 of the Business and Professions Code even though such school does not purport to offer instruction leading to licensure under the Clinical Laboratory Technology Act."

Cited was Section 1289, which provides, "It is unlawful for any person to operate a school or conduct any course for the purpose of training or preparing persons for a license hereunder or to perform any of the practices or acts herein defined without having first secured the approval of the department as herein provided."

Malaria Blood Still Available for Neurosyphilis Treatment

Physicians desiring to use malarial fever therapy for patients with paresis who have not responded to other types of treatment for neurosyphilis can still obtain malaria blood from the Laboratory of Tropical Diseases at Columbia, South Carolina.

The laboratory is the only facility in the United States which still maintains human malaria blood for therapeutic purposes. Both quartan and tertian strains are maintained there.

Although malarial fever therapy is no longer used routinely, since most authorities agree that penicillin alone is just as effective in cases of neurosyphilis as penicillin plus fever therapy, the State Department of Public Health still receives occasional inquiries concerning the availability of the treatment.

Inquiries should be addressed to Dr. Robert C. Rendtorff, acting director of the laboratory, National Microbiological Institute, P. O. Box 717, Columbia, South Carolina.

In requesting the blood, the physician should state the race of the patient and whether he previously has had malaria, since this determines the strain supplied.

Lipreading Scholarship Available for Teacher Training

Competition for the annual Kenfield Memorial Scholarship for prospective teachers of lipreading opened March 1st, with application deadline announced as May 1st.

Winner of the award, given annually by the American Hearing Society, is entitled to take a teacher training course in lipreading from any school or university in the United States acceptable to the Teachers Committee.

Applications should be mailed to Mrs. Eleanor C. Ronnei, care of the New York League for the Hard of Hearing, 480 Lexington Avenue, New York City. The winner will be announced during National Hearing Week, May 2d-8th.

Requirements for applicants include legible lips, good speech and voice and a college degree with a major in education, psychology or speech.

Alcoholism Institute Planned for Nurses in July

An institute on alcoholism for registered professional nurses will be held July 29th-31st at Yale University to acquaint them with the nature and extent of alcoholism, and with theories concerning the etiology of addiction.

Attention will be directed toward the effectiveness of various treatment resources, with particular emphasis on the role of the nurse in interpreting to patients or to their families the nature of alcoholism and the necessity of securing specialized assistance following hospital treatment for acute intoxication.

Inquiries should be addressed to the Yale Center of Alcohol Studies, 52 Hillhouse Avenue, Yale Station, New Haven, Connecticut.

Sanitary Engineering Advisors

Two local health officers have been appointed by the State Board of Public Health to serve on the Department's Advisory Committee on Sanitary Engineering. They are Roy C. Gilbert, M.D., Los Angeles County Health Officer, and Raymond C. Leer, M.D., Santa Cruz County Health Officer. Both are members of the Committee on Administrative Practices of the California Conference of Local Health Officers. Dr. Leer is CAP chairman.

When the eight other members of the Advisory Committee on Sanitary Engineering were appointed by the State Board in January it was indicated that two health officers would be nominated by the Conference of Local Health Officers and added later.

SPECIAL CENSUS RELEASES

Special Censuses of California cities. Series P-28:

Del Norte County—Crescent City (558); Kern County—Delano (575); Los Angeles County—Alhambra (566), Lynwood (576), Torrance (578); Marin County—Corte Madera (574), Mill Valley (561), San Rafael (577); Mendocino County—Ukiah (556); Merced County—Los Banos (573); Orange County—Anaheim (569), Fullerton (571); Stanislaus County—Newman (568); Ventura County—Ojai (559); Port Hueneme (562).

Copies of these releases may be obtained from: Library, Bureau of Foreign and Domestic Commerce, U. S. Department of Commerce at 315 Flood Building, 870 Market Street, San Francisco, California, or at 502 Rives-Strong Building, 112 West Ninth Street, Los Angeles, California.

In ordering specify Series P-28 and number as shown above.

Florence Shackelford McKinnon Retires After 43 Years

Mrs. Florence Shackelford McKinnon, senior stenographer-clerk in the Division of Laboratories of the State Department of Public Health, has retired after 43 years of service with the division. Mrs. McKinnon began her career January 1, 1911, as secretary to the late Dr. W. A. Sawyer, laboratory director at that time. During succeeding years she served as secretary to Dr. W. H. Kellogg until his retirement in 1941. In 1932 she was appointed senior stenographer-clerk, in which capacity she served until her retirement. Much of her time during these years was devoted to the clerical phases of the fiscal and budgetary activities of the division.

Mrs. McKinnon saw the division grow from a staff of less than 10 to an organization containing several laboratories, each employing many more persons than the original laboratory. During this time the laboratory undertook the preparation and administering of rabies vaccine, the preparation and distribution of *ophthalmia neonatorum* prophylactic outfits and triple typhoid vaccine, the initiation of premarital and prenatal serologic tests, the development of licensure and certification of clinical laboratory technicians and public health bacteriologists, and many other activities in the division.

Composting of San Quentin Wastes Studied by Department and U. C.

The Bureau of Vector Control of the State Department of Public Health has been taking part in a cooperative investigation of the possibilities of disposing of San Quentin wastes by composting. The investigation was initiated by H. O. Teets, Warden of San Quentin, who became interested in the possible solution of the fly problem at San Quentin and the development of a saleable product in compost after the University of California's Institute of Sanitary Engineering Research recently reported on composting as a method of utilization and disposal of municipal refuse.

An investigation by the Bureau of Vector Control revealed that cow and hog manure, garbage and other organic wastes at San Quentin were heavily infested with fly larvae and that in spite of insecticide spraying and other control measures, adult flies were a severe problem at the institution. Since mixed refuse had been used in the university compost investigations, the possibility of extending this knowledge by composting heavily infested manure was considered sufficiently important to warrant detailed study.

In the cooperative investigation undertaken for the purpose, university officials gave technical direction to the project; Bureau of Vector Control personnel investigated the survival of fly larvae during composting; and prison officials furnished the necessary labor and materials. Five different mixtures of manure and garbage were composted experimentally and a report on the results is currently being prepared.

Foreign Jobs for Health Educators

The U. S. Public Health Service is recruiting for health educators to fill existing vacancies in various parts of the world. There are about 12 assignments open at the present time, according to Dr. Robert L. Zobel, Chief of the Health Services Branch, Division of International Health, Public Health Service. Qualified health educators interested in foreign experience should contact Dr. Zobel at the Washington, D. C. headquarters of PHS.

